



THE BASICS

Hospital Discharge Planning in Medicare: Current Requirements and Proposed Changes

FEBRUARY 9, 2016

This publication reviews the discharge planning services requirements for hospitals¹ in the Medicare program as well as changes recently proposed by the Centers for Medicare & Medicaid Services (CMS). Medicare sets minimum health and safety standards for hospitals, known as conditions of participation (CoPs), to protect beneficiaries and ensure quality care. The conditions require that hospitals provide discharge planning services to help manage transitions from the hospital to home or other health care settings, such as skilled nursing facilities or rehabilitation hospitals.² Discharge planning includes “determining the appropriate post-hospital destination for a patient; identifying what the patient requires for a smooth and safe transition...; and beginning the process of meeting the patient’s identified post-discharge needs.”³

Compliance with the conditions of participation is monitored through a survey and certification process overseen by CMS. The survey (or inspection) for this determination is done on behalf of CMS by individual State Survey Agencies (SSAs) which are typically housed in the state’s health or public health department, or other unit of state government. The State Operations Manual prepared by CMS includes interpretive guidance to help SSAs evaluate the adequacy of hospitals’ discharge planning processes. CMS also deems hospitals as meeting Medicare CoPs if they receive accreditation from a CMS-approved accrediting organization such as The Joint Commission or the American Osteopathic Association.⁴ About 75 percent of all hospitals are accredited by The Joint Commission.⁵

DISCHARGE PLANNING REQUIREMENTS

Current regulations require hospitals to have a discharge planning process that applies to all inpatients.⁶ Patients likely

to “suffer adverse consequences upon discharge” in the absence of a discharge plan must be identified by the hospital.⁷ The hospital must provide such patients with a discharge planning evaluation that assesses (i) the likelihood of the patient needing post-hospital services and of the availability of the services and (ii) the patient’s capacity for self-care or being cared for in the environment from which he or she entered the hospital. The hospital is required to discuss the results of the evaluation with the patient or a representative acting on his or her behalf, and to use the evaluation to establish an appropriate discharge plan. If a patient is determined to need a discharge plan, then a registered nurse, social worker, or other qualified person must develop or supervise the development of a discharge plan. Even if the hospital does not identify the need for a discharge plan, the patient’s physician may request one, which the hospital must provide.

The CoPs also require the hospital to arrange for the initial implementation of the patient’s discharge plan. Specifically, a hospital is required to:

- counsel patients and family members to prepare them for post-hospital care,
- supply lists of local Medicare-participating skilled nursing facilities (SNFs) and home health agencies (HHAs) to patients when these services are indicated. Hospitals may not make recommendations about which facility or provider to use and must identify any HHA or SNF in which they have a disclosable financial interest.
- transfer or refer patients, along with appropriate medical records, for follow up and ancillary care as needed, and
- reassess its discharge planning process and discharge plans to ensure they are responsive to patients’ discharge needs.

PROPOSED RULE

On November 3, 2015, CMS published a proposed rule to revise the discharge planning component of the hospital CoPs.⁸ The proposed rule responds to a provision of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) that requires modification of the CoPs and interpretive guidance pertaining to discharge planning issued by CMS every five years.⁹ Comments on the proposed rule were due January 4, 2016.

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In explaining the rationale for changes included in the rule, CMS expressed concern that there is too much variation in the discharge planning process. Poorly executed discharge planning can lead to complications and avoidable readmissions, which have negative consequences for both patients and the Medicare program.¹⁰

Perhaps the biggest change is a new requirement that hospitals apply the discharge planning process to *all* patients, including inpatients, outpatients under observation status, outpatients undergoing sedated procedures or surgery, and emergency department patients identified as needing a discharge plan. Hospitals are also required to provide a discharge evaluation for all patients, not just those at risk for experiencing adverse consequences post-discharge. This requirement is aimed at ensuring that more patients who might experience complications and costly readmissions are identified.

A second significant change is a requirement that a copy of the discharge instructions and the discharge summary be sent to the practitioner responsible for the patient's follow-up care within 48 hours of discharge; test results must be communicated within 24 hours of their availability. Again, this provision is aimed at smoothing transitions and ensuring that patients receive timely follow-up care.

Thirdly, in line with CMS's goal of reducing avoidable hospital readmissions, the proposed rule includes a new requirement that hospitals establish a post-discharge follow-up process to check on patients who return home. The rule does not prescribe a follow-up strategy or specify the timing of these activities, leaving hospitals flexibility to design their own programs.

Additional provisions of the new rule are highlighted below:

- A new design standard requires that the discharge planning process be approved by the hospital's governing body and documented in writing.
- Explicit time frames for completing evaluations and discharge plans are specified. The evaluation process, for example, must take place within 24 hours of admission or registration, and the plan must be completed before discharge. Patients must be evaluated throughout their stay and discharge plans revised as needed.
- The rule requires active involvement of patients, caregivers, and responsible clinicians in the evaluation and plan development

process. Plans must take into account the patient's goals of care and treatment preferences.

- The rule requires hospitals to include specific, detailed information in the instructions for patients discharged to home. This includes written information on warning signs and symptoms that may indicate the need to seek immediate medical attention, a complete list of prescription and over-the counter medications, reconciliation of pre-admission and discharge medications, and complete information about follow-up care and appointments.
- In addition to giving patients lists of post-acute care providers, hospitals must help patients and their caregivers select providers by using and sharing data on quality and resource use measures as required by the IMPACT Act.
- Without mandating a specific transfer form, the rule requires hospitals to transmit specific, detailed data for patients transferred to another health care facility such as a SNF or a long-term care facility. The use of certified health information technology to accomplish the transmittal of these data is encouraged but not required.
- Hospitals must rigorously assess their discharge planning processes on a regular basis and establish an ongoing review of a representative sample of discharge plans, including those for patients who were readmitted within 30 days.

Although not required by the rule, CMS also calls for hospitals to “improve their focus on psychiatric and behavioral health patients, including patients with substance use disorders” and notes that discharge planning will be more successful for all patients if discharge planning teams are aware of the “full range of post-hospital services available in the community, including non-medical services and supports.”¹¹ Hospitals are encouraged, but not required, to form partnerships with area agencies on aging (AAAs), aging and disability resource centers (ADRCs), centers for independent living (CILs), and other organizations that provide or connect medical and non-medical services to older adults and persons with disabilities. Hospitals are also encouraged to make use of their state's Prescription Drug Monitoring Program (PDMP) to help identify and, where possible, intervene proactively with patients at high risk for abusing opioids.

A final rule will be issued after CMS has reviewed comments.

ENDNOTES

1. The scope of this publication is limited to the discharge planning requirements of acute care hospitals. Critical access hospitals and long-term care hospitals also have requirements for discharge planning, as do other providers who participate in the Medicare program, such as skilled nursing facilities and home health agencies.
2. Hospital Conditions of Participation for discharge planning are found at 42 CFR §482.43, <https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec482-43.pdf>.
3. State Operations Manual, Appendix A – Survey Protocol, Regulations and Interpretive Guidance for Hospitals, Rev. 151, November 20, 2015, p. 412, www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf.
4. “CMS-Approved Accrediting Organizations, Contacts for Prospective Clients,” September 2, 2015, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Accrediting-Organization-Contacts-for-Prospective-Clients-.pdf>.
5. The Joint Commission, “Facts about Hospital Accreditation,” January 29, 2016, www.jointcommission.org/facts_about_hospital_accreditation.
6. The regulation states that discharge planning must apply to all patients, but CMS clarified in guidance that the preamble to the regulation makes it clear that discharge planning presupposes hospital admission. Discharge planning requirements were not intended to apply to outpatients. See Revision to State Operations Manual, Hospital Appendix A – Interpretive Guidelines for 42 CFR 482.43, Discharge Planning, p. 413. Note that this is one detail that could be subject to change should the Proposed Rule, cited below, go into effect.
7. 42 CFR §482.43 (a).
8. “Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, A Proposed Rule by the Centers for Medicare and Medicaid Services,” November 3, 2015, <https://www.federalregister.gov/articles/2015/11/03/2015-27840/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals>.
9. Improving Medicare Post-Acute Care Transformation Act of 2014, Public Law 113-185, October 6, 2014, 128 STAT 1960, <https://www.gpo.gov/fdsys/pkg/PLAW-113publ185/pdf/PLAW-113publ185.pdf>.
10. “Medicare and Medicaid Programs, Proposed Rule,” p. 68127.
11. “Medicare and Medicaid Programs, Proposed Rule,” p. 68127.